U.S. Department of Labor

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Issue Date: 20 April 2007 Case No: 2006-BLA-05286

In the Matter of

G. M.,
Claimant

v.

ARCH OF ALABAMA, INC.,
Employer/Self-Insured

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: PATRICK NAKAMURA, Esq.
For Claimant

MICHAEL E. TURNER, Esq.
For Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

Pursuant to § 725.455, a hearing was held before me in Birmingham, Alabama, on September 28, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issued are presented for adjudication.[1]

(1) Whether Claimant has pneumoconiosis;
(2) Whether Claimant's pneumoconiosis arose from his coal mine employment;
(3) Whether the Claimant is totally disabled;
(4) Whether the Claimant's total disability, if any, is due to pneumoconiosis; and
(5) Whether the Claimant has established a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d).

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on June 8, 2004 (DX 3). On September 26, 2005, the District Director issued a proposed Decision and Order denying benefits to the Claimant (DX 28). The Claimant requested a formal hearing on October 3 and 5, 2005 (DX 29, 30). The matter was then referred to the Office of Administrative Law Judges for a formal hearing and later was assigned to me.

This is a subsequent claim for benefits. See § 725.309(d). The record reflects that the Claimant filed a Claim for benefits in August 2000, which was finally denied in October 2000. (DX 1). Regarding the prior Claim, the District Director found that the Claimant had not established any of the elements of entitlement to benefits (DX 1). The Claimant did not appeal that determination.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in February 1941 and, therefore, is 65 years old. He is married, and has no dependents other than his wife (DX 3, 10). He worked in the mines for 20 years, ending in 1987. His last coal mine employment was with Arch of Alabama, Inc., which ended when the mines shut down (DX 3).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. He stated that he first worked in coal mine employment as a driller on the overburden. The Claimant next worked oiling equipment

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the September 28, 2006 hearing. At the hearing, the Employer withdrew its controversion of the issue of timeliness of the Claimant's Claim (T. at 32). The parties stipulated that the Claimant has 20 years of coal mine employment (T. at 31). I find that the record supports this stipulation.

and then operating heavy equipment. He ran a drag line in strip mine operations. He also worked dredging slurry ponds and on the washer. His final employment with the named Employer was operating heavy equipment. The Claimant worked in self-employment following his coal mine employment, primarily helping his wife with chicken houses.

The Claimant uses a wheel chair because of his muscle disease. He testified he is short of breath and cannot maneuver his wheel chair up a small grade. The Claimant also testified he smoked from the age of 16 until he stopped in 1989, for a total of 32 years, from one to two packs of cigarettes daily. The Claimant is treated by Dr. Johnson for his breathing difficulties. Dr. Johnson has prescribed albuterol and prednisone, and also has prescribed the CPAP medical equipment that the Claimant uses at night for his sleep apnea. The Claimant testified he had a stent put in a clogged artery in February 2004. (T. at 35-45, 49-54).

C. Relevant Medical Evidence

The Claimant presented a medical report from Dr. Jeffrey Hawkins (CX 7). The medical report referred to a physical examination, and also to X-ray, pulmonary function studies, and arterial blood gas tests that Dr. Hawkins administered. In addition, in his affirmative case the Claimant presented interpretations of X-ray films dated February 23, 2005 (2/23/05) (CX 1) and July 6, 2005 (7/6/05) (CX 3) as well as rebuttal interpretations of the 2/23/05 (CX 2, 6) and 7/6/05 (CX 5) X-rays.

The Employer presented a medical report from Dr. Allan Goldstein, a pulmonary specialist (DX 14). This medical report referred to a physical examination and also to X-ray, pulmonary function studies and arterial blood gas tests that Dr. Goldstein performed. In addition, in its affirmative case, the Employer presented interpretations of X-rays dated 7/6/05 (DX 14) and 8/2/06 (EX 1); in rebuttal, the Employer submitted interpretations of the 2/23/05 (DX 14) and 7/6/05 (DX 14) X-rays.

Also included in the record is a medical report by Dr. Zakir Khan, a board certified internist (DX 13). Dr. Khan was the physician who conducted the pulmonary evaluation, on behalf of the Department of Labor, in conjunction with the Claimant's claim. This evaluation included a physical examination, chest X-ray, pulmonary function tests, and arterial blood gas tests. See § 725.406.

By motion filed prior to the hearing and at the hearing, the Employer objected to my consideration of various items the Claimant proffered as evidence. I advised the parties that I would address the evidentiary issues in this Decision, and invited them to discuss the evidentiary aspects of this matter in their post-hearing briefs.[2]

The Employer's first objection dealt with the X-ray interpretations the Claimant submitted in rebuttal. This included an objection to the Claimant's proffer of an X-ray interpretation to rebut Dr. Nath's interpretation of the Claimant's 2/23/05 X-ray, which was part of his pulmonary evaluation under § 725.406, and which was positive for pneumoconiosis. The

[2] The Employer renewed some of its objections in its post-hearing brief.

Employer asserted that the Claimant could not "rebut" a positive X-ray with another positive X-ray.[3] Additionally, the Employer objected to the Claimant's submission of a 2/23/05 X-ray interpretation in rebuttal of the Employer's affirmative case (CX 2). The Employer asserted that the Claimant could submit, to rebut the Employer's case, only interpretations of those X-rays the Employer submitted in its affirmative case. The Employer's affirmative case included interpretations of the Claimant's 7/6/05 and 8/2/06 X-rays. The Employer asserted that, because it had not submitted an interpretation of the 2/23/05 X-ray, it was improper for the Claimant to submit an interpretation of that X-ray in rebuttal (T. at 11-12).[4]

The Employer also objected to my consideration of Dr. Hawkins' medical report, which the Claimant submitted (CX 7). The Employer pointed out that Dr. Hawkins' report referred to the Claimant's 8/2/06 X-ray, which the Claimant had not submitted into evidence. The Employer asserted that the report should be stricken, because it violated the requirement of § 725.414(a)(2)(i), which mandates that all chest X-ray interpretations that appear in a medical report be admissible under that section's evidentiary limitations. In response to the Claimant's characterization of Dr. Hawkins' report as a treatment record, which the Claimant's counsel made for the first time at the hearing, the Employer averred that Dr. Hawkins' report appeared on its face to be a medical evaluation, not a record of treatment, and reiterated his objection to its consideration (T. at 21-26).[5]

The governing regulation sets forth limitations for admission of medical evidence in Black Lung benefits cases. Each party is entitled to submit, in support of its affirmative case, no more than two chest X-ray interpretations. § 725.414(a)(2)(i)[Claimant]; § 725.414(a)(3)(i)[Employer]. The Claimant is entitled to submit, "in rebuttal of the case presented by the party opposing entitlement," no more than one physician's interpretation of each chest X-ray submitted by the designated responsible operator and by the Director.[6] § 725.414(a)(2)(ii). In rebuttal of the case presented by the Claimant, the designated responsible operator is entitled to submit no more than one physician's interpretation of each chest X-ray submitted by the Claimant and by the Director. § 725.414(a)(3)(ii).

In Sprague v. Freeman United Coal Mining Co., B.R.B. No. 05-1020 B.L.A. (Aug. 31, 2006), the Benefits Review Board (BRB) held that an item of evidence submitted by a party in rebuttal need not contradict the specific item of evidence to which it is responsive, but only refute the "case" presented by the opposing party. Consequently, a claimant is not barred from

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[3] In its brief, the Employer acknowledged that the Benefits Review Board has addressed this particular issue.

[4] At the hearing, the Claimant also withdrew Dr. Miller's X-ray interpretation of the Claimant's 7/6/05 X-ray (CX 5). The Employer thereupon moved for the admission of this interpretation to rebut the Claimant's case, if permitted by the evidentiary limitations of § 725.414 (T. at 19).

[5] In his pre-hearing statement, filed on September 20, 2006, the Claimant characterized Dr. Hawkins' report as a "medical report" and not as a medical treatment record. See § 725.414(a)(4).

[6] The latter refers to the X-ray interpretation conducted in accordance with § 725.406, which discusses the Department's "complete pulmonary evaluation." The District Director has designated the Employer as the responsible operator in this case (DX 20).

submitting an X-ray interpretation to rebut the employer's "case" by offering an X-ray interpretation consistent with the Director's X-ray positive X-ray interpretation. Concerning the issue of limits on the X-rays a party may submit in rebuttal, the BRB in Sprague applied Ward v. Consolidation Coal Co., 23 B.L.R. 1-151 (2006), to hold that a party may rebut each X-ray interpretation that the opponent has offered by submitting an X-ray interpretation. Where a party submits multiple interpretations of the same X-ray, the opposing party may rebut with the same number of interpretations.

The holdings of Sprague and Ward can be summarized as follows:

1. A party is entitled to submit one X-ray interpretation to rebut each X-ray interpretation submitted by the opposing party in its affirmative case;
2. An X-ray interpretation submitted in rebuttal need not be of the same X-ray submitted in the opposing party's affirmative case; and
3. Either party may submit an X-ray interpretation to rebut the Director's X-ray interpretation, whether or not the party's interpretation is consistent with the Director's interpretation.

Based on the foregoing, I DENY the Employer's Motion to exclude CX 2, Dr. Cappiello's interpretation of the Claimant's 2/23/05 X-ray, submitted in rebuttal of the Employer's case. As set forth in the discussion above, in submitting X-ray interpretations in rebuttal, a party is not limited to submitting interpretations of the very same X-rays the opponent has submitted. Therefore, the Claimant may submit, and I may consider, Dr. Cappiello's interpretation of the Claimant's 2/23/05 X-ray.

I also GRANT the Employer's Motion that I consider Dr. Miller's interpretation of the Claimant's 7/6/05 X-ray, which the Claimant initially designated as CX 5 and then withdrew from consideration. As set forth in the governing regulation, as elucidated in the Ward and Sprague decisions, each party may submit up to two X-ray interpretations in its affirmative case, one X-ray to rebut the Director's X-ray interpretation, and one X-ray interpretation to rebut each interpretation its opponent submits in its affirmative case. At the hearing, the Employer submitted two X-ray interpretations in its affirmative case, one X-ray interpretation to rebut the Director's X-ray interpretation, and one X-ray interpretation to rebut the two Claimant's affirmative X-ray submissions.[7] Therefore, the Employer is entitled to submit one additional X-ray interpretation to rebut the Claimant's affirmative case, and I shall consider Dr. Miller's interpretation of the Claimant's 7/6/05 X-ray accordingly.[8]

I DENY the Employer's Motion to exclude CX 7, Dr. Hawkins' medical report. The Employer's objection to the report is based on the fact that Dr. Hawkins' report refers to Dr.

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[7] The Employer's pre-hearing statement lists the following: EX 1 (Dr. Loveless' interpretation of 8/2/06 X-ray) and DX 14 (Dr. Goldstein's interpretation of 7/6/05 X-ray) in its affirmative case; DX 14 (Dr. Loveless' interpretation of Claimant's 2/23/05 X-ray) to rebut the Director's case; and DX 14 (Dr. Loveless' interpretation of Claimant's 7/6/05 X-ray) to rebut the Claimant's affirmative case.

[8] This item shall be designated as EX 3.

Loveless' interpretation of the Claimant's 8/2/06 X-ray, which the Claimant did not proffer as evidence. The regulation requires that any X-ray interpretation referred to in a medical report the Claimant proffers must be admissible "under this paragraph or paragraph (a)(4) of this section." § 725.414(a)(2)(i).[9]

However, as the BRB has repeatedly stressed, an administrative law judge has broad discretion to fashion an appropriate remedy, when a medical report refers to evidence which has not been admitted. See, e.g., Harris v. Old Ben Coal Co., B.R.B. No. 04-0812 B.L.A. (Jan. 27, 2006)(en banc). Most recently, in Keener v. Peerless Eagle Coal Co., 23 B.L.R. 1-___, B.R.B. No. 05-1008 B.L.A. (Jan. 26, 2007) (en banc), the Board noted that the administrative law judge has several options in handling a report based, in part or in whole, on evidence not admitted in the claim -- such as excluding the report, redacting the objectionable content, asking the physician to submit a new report, or "factoring in the physician's reliance upon the inadmissible evidence when deciding the weight to which his opinion is entitled." The Board specifically stated, however, that "exclusion is not a favored option, because it may result in the loss of probative evidence developed in compliance with the evidentiary limitations." Id., at fn. 15.

Following the Board's specific statement that "exclusion is not a favored option," I deny Employer's motion to exclude Dr. Hawkins' report. As Dr. Hawkins' medical report is the most recent evidence regarding the Claimant's condition, and as the Claimant has proffered no other medical report, striking Dr. Hawkins' entire report would be excessive. However, because the Claimant has not submitted the 8/2/06 X-ray, I will disregard Dr. Hawkins' reference to Dr. Loveless' interpretation of that film. The remainder of his report is admissible, and will be considered.[10]

These items will be discussed in greater detail below.

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[9] However, as the Claimant pointed out, the Employer proffered this X-ray interpretation in its affirmative case; therefore, the X-ray interpretation to which Dr. Hawkins refers is included in the record (T. at 22). Section 725.414(a)(3)(i), which discusses evidence in medical reports the responsible operator submits, has a corresponding provision limiting evidence to that admissible under that paragraph or paragraph (a)(4). Although these provisions do not specifically require that the party which submitted the medical report also be the party that submitted the X-ray interpretation, that is clearly what must be intended. Otherwise, if the word "paragraph" were construed to mean all of § 725.414, or all of § 725.414(a), the remark that evidence may admissible "under paragraph (a)(4) of this section" would not be necessary.

[10] Consistent with the Claimant's pre-hearing statement, I also find that Dr. Hawkins' report constitutes a medical report, as defined in § 725.414(a)(1), and not as a medical treatment record, as described in § 725.414(a)(4). See Stamper v. Westerman Coal Co., B.R.B. No. 05-0946 B.L.A. (July 26, 2006)(per curiam). The Claimant has not submitted any other medical reports; thus, his submission of Dr. Hawkins' medical report is well within the evidentiary limitations, which limit each party to two medical reports. See, e.g., § 725.414(a)(2)(i).

D. Entitlement

Because this claim was filed more than a year after the final denial of the Claimant's previous claim, it is considered a subsequent claim. A subsequent claim must be denied unless the Claimant can demonstrate that one or more applicable conditions of entitlement have changed since the final denial of the prior claim. § 725.309(d). As § 725.309(d) states, the following rules pertain to the adjudication of subsequent claims:

> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based…. [I]f the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously;
> (3) If the applicable conditions of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.

In October, 2000, the District Director found that the Claimant had not established any of the elements of entitlement. The focus of this Decision, therefore, must be on all elements of the claim: whether the Claimant has pneumoconiosis, whether his pneumoconiosis, if present, arose from coal mine employment; whether the Claimant is totally disabled; and whether the Claimant's total disability is due to pneumoconiosis. However, if the Claimant establishes a change in one or more of these conditions of entitlement, he still bears the burden of proving the remaining conditions of entitlement. § 725.309(d)(4). See National Mining Ass'n v. Dep't of Labor, 292 F.3d 849, 861 (D.C. Cir. 2002).

1. Elements of Entitlement:

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence; (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as

pneumoconiosis, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

X-ray evidence: § 718.202(a)(1).
Biopsy or autopsy evidence: § 718.202(a)(2).
Regulatory presumptions: § 718.202(a)(3).[11]
Physician opinion based upon objective medical evidence: § 718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

Date of X-Ray	Ex.No.	Physician	Radiological Credentials[12]	Interpretation

[11] These are as follows: (a) an irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[12] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention,

02/23/2005	DX 13	Nath	BCR, B reader	1/1 q, q, 4 lung zones. Box checked: "em" [emphysema]
02/23/2005	CX 2	Cappiello	BCR, B reader	1/0, p, p, 6 lung zones. Box checked: "em." Comments: "There is hyperinflation of the lungs with changes of underlying chronic obstructive pulmonary disease….There are scattered small rounded parenchymal opacities throughout the six lung zones…"
02/23/2005	DX 14	Loveless	BCR, B reader	0/1, q, p, 4 lung zones. Comments: "Would recommend repeat CXR [chest X-ray] because of the film quality issues – the parenchymal pattern could be 0/0 (normal) ….the pleural changes could be due to pleural fat – obliques or C.T."
02/23/2005	CX 6	Miller	BCR, B reader	1/0 p, q, 6 lung zones. Box checked: "em." Comments: "multiple bilateral small round opacities….there are changes of chronic obstructive pulmonary disease"
02/23/2005	CX 1	Ahmed	BCR, B reader	1/0 p, p, 6 lung zones. Box checked: "em." Comments: "Minute soft rounded parenchymal densities measuring up to 1.5 mm are seen scattered throughout both lungs….There are changes of chronic obstructive pulmonary disease"
07/06/2005	DX 14	Goldstein	B reader[13]	No pneumoconiosis. Comment: "? hyperinflation"
07/06/2005	CX 3	Ahmed	BCR, B reader	1/0 p, q, 6 lung zones. Boxes checked: "aa" [atherosclerotic aorta] "em" "pi" [other significant abnormality]. Comments: "Minute soft rounded parenchymal densities measuring up to 3 mm. are seen scattered throughout the lower four zones….changes of chronic obstructive pulmonary disease….atherosclerotic changes of aorta."

in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

[13] Dr. Goldstein's professional qualifications are not included in the record. The Employer asserted, in its pre-hearing statement, that Dr. Goldstein is a B reader. Consistent with my Order of May 23, 2007, I verified Dr. Goldstein's qualification as a B reader through the internet. See link at http://www.oalj.dol.gov/ with B reader listing (as of February 2007).

07/06/2005	CX 4	Cappiello	BCR, B-reader	1/0 p, p, 6 lung zones. Box checked: "em." Comments: "There is hyperinflation of the lungs with changes of chronic obstructive pulmonary disease….there are scattered small predominately rounded parenchymal opacities throughout both lungs varying in size from a fraction of a millimeter up to approximately 1.5 mm in diameter."
07/06/2005	DX 14	Loveless	BCR, B reader[14]	0/1 s, p, 4 lung zones. Comments: "0/1 persists. Stable pleural changes….question hyperinflation (COPD)" [chronic obstructive pulmonary disease]
07/06/2005	EX 3	Miller	BCR, B reader	0/1, s, p, 6 lung zones. Box checked: "em." Comments: "multiple bilateral small irregular and round opacities ranging in size up to approximately 1.5 mm ….there are changes of chronic obstructive pulmonary disease"
08/02/2006	EX 1	Loveless	BCR, B reader	0/0. Comments: "no definite parenchymal small opacities in the chest….hemidiagphram flattening suggests COPD"

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

The listing above shows that Dr. Nath, Dr. Miller, and Dr. Ahmed, who all are dually-qualified as Board-certified radiologists and B readers, interpreted as positive the same X-ray film, taken on 2/23/05. This same x-ray film was also interpreted as negative by Dr. Loveless, who has the same professional qualifications.[15] Also, two dually qualified physicians, Dr. Ahmed and Dr. Cappiello, interpreted the July 6, 2005 x-ray film as positive for pneumoconiosis, while Dr. Miller, Dr. Loveless and Dr. Goldstein found the x-ray film was negative for

[14] Dr. Loveless' professional qualifications are not included in the record. The Employer asserted, in its pre-hearing statement, that Dr. Loveless is a Board-certified radiologist and B reader. Consistent with my Order of May 23, 2007, I verified his qualifications through the internet. See http://www.abms.org. See also link at http://www.oalj.dol.gov/ with B reader listing (as of February 2007).

[15] Dr. Loveless noted opacities but stated that the film was of limited quality and it was possible that the reading could be completely negative.

pneumoconiosis.[16] As noted above, Dr. Loveless is dually-qualified, and Dr. Goldstein is a B reader but not a Board-certified radiologist. Finally, the x-ray film of August 2, 2006 was found to be negative by Dr. Loveless. I accord greater weight to the readings by the physicians with dual qualifications.

Accordingly, the greater weight of the evidence regarding the x-ray film of February 23, 2005 is that it is positive for pneumoconiosis; four of the five dually-qualified physicians opined that this film was positive for the disease. I find that the film of 7/6/05 is equivocal for pneumoconiosis; there are five opinions, two positive and three negative. One of the negative opinions was proffered by a B reader who is not dually-qualified, and the other opinions are all from dually-qualified physicians. The only interpretation of the film of August 2, 2006, by the dually-qualified Dr. Loveless, is negative for pneumoconiosis.

In summary, of the three X-rays, the weight of one is positive for pneumoconiosis, and the weight of one is negative for pneumoconiosis, and the third is equivocal. I find, therefore, that the X-ray evidence of pneumoconiosis is in equipoise. Consequently, because the burden to establish this element is upon the Claimant, I must find that the Claimant has not established that he has pneumoconiosis based upon X-ray interpretations. See Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994). This represents no change from the denial of the Claimant's previous claim, in 2000.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms,

[16] Dr. Loveless, however, noted opacities in profusion 0/1 on this film.

pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. As stated above, the definition in § 718.204(a) of pneumoconiosis includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis. Therefore, a physician opinion may be expected to discuss either "clinical" pneumoconiosis, or "legal" pneumoconiosis, or both.

The record contains the following physician opinions:

Dr. Zakir Khan (DX 13)

As noted above, Dr. Khan, who is Board-certified in internal medicine, conducted a pulmonary evaluation of the Claimant on behalf of the Department of Labor, as required under § 725.406. He submitted a written report using Department of Labor forms. Attached to Dr. Khan's report is a copy of that portion of the Claimant's claim summarizing his coal mine employment. Dr. Khan's report does not reflect any additional information about the Claimant's work history, but it does reflect that the Claimant had a history of tobacco use from 1957 to 1989.

In his report, Dr. Khan stated that the Claimant had the following conditions: pneumoconiosis, based on the Claimant's history, physical examination findings, pulmonary function study results, and chest x-ray; and ischemic heart disease, based on the Claimant's history. Dr. Khan's report did not specify whether the Claimant had "legal" pneumoconiosis or "clinical" pneumoconiosis, or both. On physical examination, Dr. Khan noted bilateral wheezing. He noted that the Claimant's X-ray showed small rounded opacities and evidence of emphysema; that the pulmonary function test showed severe obstructive lung disease with significant bronchodilator response and impaired membrane function; and his arterial blood gas test was normal at rest, with the Claimant unable to exercise.[17] Dr. Khan also stated that the Claimant's pneumoconiosis was due to coal mine dust exposure and cigarette smoking, while his ischemic heart disease was due to coronary artery disease.

In his report, Dr. Khan stated that Claimant would be unable to perform his last coal mine employment due to "respiratory impairment," and he also stated that the Claimant's impairment was due to the diagnosed conditions to a "significant extent." Dr. Khan also noted that the Claimant's degenerative muscle disease in his lower extremities impacted the Claimant's ability to perform his coal mine work to some extent.

Dr. Allan Goldstein (DX 14)

At the Employer's request, Dr. Allan Goldstein, who is Board-certified in internal medicine and pulmonary medicine, examined the Claimant in July 2005 and submitted a written

[17] The notes accompanying the arterial blood gas test report stated that the Claimant was unable to exercise due to "muscles in legs deteriorating."

report.[18] Dr. Goldstein's report reflects that the Claimant had a coal mine employment history of 25 years in surface mines as a heavy equipment operator and that the Claimant had a 25 to 30 year smoking history, and quit smoking 16 or 17 years earlier. The Claimant reported a heart attack several years prior to the examination, and told Dr. Goldstein that he had shortness of breath for approximately two years prior to the heart attack and had worsening shortness of breath since that time. He had gained 40 to 50 pounds since he retired and currently weighed 239 pounds at 74 inches tall. Dr. Goldstein administered a chest X-ray, pulmonary function test, and arterial blood gas test; his report is based in part on the results of those tests, which are appended to his report (DX 14).

In his written report, Dr. Goldstein noted no abnormalities related to the Claimant's respiratory system in his physical examination. He noted that the Claimant was limited by his orthopedic conditions and was known to have sleep apnea. Dr. Goldstein also reported that the Claimant had no nodular changes on his chest x-ray, but had some suggestion of hyperinflation, and also noted that the Claimant demonstrated an obstructive defect with borderline reversibility, some hyperinflation, and normal diffusion on pulmonary function study. The Claimant's blood gas test showed normal results.

Dr. Goldstein concluded that the Claimant did not have coal worker's pneumoconiosis. He stated that with the degree of limitation exhibited by the Claimant's shortness of breath, if it were due to coal worker's pneumoconiosis, Claimant would have abnormal findings on his chest X-ray. Dr. Goldstein stated in his report that he believed the Claimant's shortness of breath was due to a combination of the Claimant's protuberant abdomen, sleep apnea, weight gain since retirement, deconditioning and possible cardiac disease. Dr. Goldstein concluded that the Claimant's findings were consistent with obstructive airway disease with some hyperinflation, and that these conditions were consistent with the Claimant's past cigarette smoking history and would contribute to his shortness of breath (DX 14).

Dr. Jeffrey Hawkins (CX 7)

At the request of the Claimant, Dr. Hawkins examined the Claimant in August 2006 and submitted a written report. Dr. Hawkins, who is Board-certified in internal medicine, pulmonary medicine and critical care, conducted a physical examination of the Claimant, took a medical and work history, and administered a chest X-ray, pulmonary function tests, and arterial blood gas tests.

In his written report, dated August 2 and August 15, 2006, Dr. Hawkins noted Claimant's history of coal mine employment as well as his history of smoking for 30 years.[19] Dr. Hawkins

[18] Dr. Goldstein's professional qualifications are not in the record. Consistent with my Order of May 23, 2006, I obtained Dr. Goldstein's professional qualifications through use of the internet. See http://www.abms.org.

[19] Dr. Hawkins' report of August 2, 2006 reflects that a chest X-ray was administered that day. His report of August 15, 2006 reflects, among other things, the interpretation of that X-ray. Both reports are titled "Clinical Consultation;" the first page of both reports are identical, listing the Claimant's medical and work history and his medications. Because these two reports clearly

also discussed the Claimant's medical history, including chronic obstructive pulmonary disease, chronic bronchitis, coronary artery disease, and polymyositis, diagnosed in 2000 with muscular weakness, which rendered the Claimant unable to stand. The Claimant had been unable to walk since suffering a broken leg the previous year, and was on corticosteroid therapy. On physical examination, Dr. Hawkins noted decreased breath sounds bilaterally and edema in both ankles. The Claimant reported occasional wheezing and some leg swelling, both before and after his myrocardial infarction.

In his initial assessment, conducted before the Claimant's X-ray was obtained, Dr. Hawkins listed the following issues: respiratory insufficiency/coal worker's (sic) pneumoconiosis evaluation/chronic obstructive pulmonary disease/ploymyositis with neuromuscular weakness/coronary artery disease, status post myocardial infarction. He noted that the Claimant "is very limited regarding exertional dyspnea with minimal activity. This is likely multifactorial in etiology. [The Claimant] worked as a surface coal miner for many years (26 by his recollection) and certainly there is an element of impairment from his exposure."

In his follow-up report, conducted after the Claimant's X-ray interpretation was received, Dr. Hawkins concluded that the Claimant had coal worker's (sic) pneumoconiosis and was totally disabled by resting and exertional dypsnea. Pulmonary function study results showed a moderate airflow obstruction with hyperinflation and normal diffusion capacity. In addition, Dr. Hawkins stated that the Claimant's results were adequate on blood gas study. Dr. Hawkins concluded that the Claimant's current respiratory impairment was due to multiple factors, including underlying chronic obstructive pulmonary disease and polymyositis. According to Dr. Hawkins, "there is certainly chronic obstructive pulmonary disease with chronic bronchitis and asthmatic bronchitis, defined by clinical history, roentenographic findings and pulmonary function studies. Coal mine dust exposure would likely have accentuated his chronic obstructive pulmonary disease." Noting that the Claimant stopped smoking in 1989, Dr. Hawkins also stated that Claimant's "underlying coronary artery disease and, perhaps significantly, the polymyositis with continuous muscle weakness, add substantial impairment to the respiratory component" (CX 7).

Discussion

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

As set forth above, Dr. Khan, who is not Board-certified in pulmonary disease, diagnosed the Claimant with pneumoconiosis. Dr. Khan's opinion is based, in part, on an X-ray

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reflect a single evaluation, I considered them to be one medical report, as defined in § 725.414(a)(1).

interpretation, by a dually qualified physician, which was positive for pneumoconiosis. Dr. Khan also cited the Claimant's physical examination, which showed abnormalities, and pulmonary function test results. On the other hand, Dr. Goldstein, who is a Board-certified pulmonary specialist, concluded that the Claimant did not have coal workers' pneumoconiosis, and attributed the Claimant's chronic obstructive pulmonary disease and respiratory impairment to a host of factors other than coal mine dust exposure. Dr. Hawkins, also a Board-certified pulmonary specialist, diagnosed the Claimant with "coal worker's (sic) pneumoconiosis" and concluded that the Claimant's coal mine dust exposure would "likely have accentuated" the Claimant's chronic obstructive pulmonary disease.

Dr. Khan's professional credentials are not as extensive as those of the other two physicians. Therefore, based on professional credentials alone, in general I would give less weight to Dr. Khan's conclusion that the Claimant has pneumoconiosis, than I give to the conclusions of the other physicians. However, I find that Dr. Khan's opinion, while succinct, cites objective factors as the basis for his conclusions. Based on the evidence before Dr. Khan, which included a positive X-ray interpreted by a dually-certified physician, I find that Dr. Khan's conclusion, that the Claimant had pneumoconiosis, is well-reasoned. I find that his diagnosis is sufficient in that it uses the term pneumoconiosis, bases it on several factors, and attributes the Claimant's condition, at least in part, to the Claimant's "coal mine work."[20]

Dr. Goldstein concluded that the changes on the Claimant's pulmonary function study consistent with obstructive airways disease and hyperinflation on chest X-ray were consistent with the Claimant's past cigarette smoking history. Dr. Goldstein did not discuss, however, whether the Claimant's past coal mine dust exposure also contributed to these changes and to the Claimant's resultant pulmonary condition. Dr. Goldstein attributed the Claimant's "shortness of breath" to several factors, but not his coal mine dust exposure. Because the evidence establishes that the Claimant stopped smoking many years ago, and that the Claimant had a long-standing history of coal mine employment, Dr. Goldstein's failure to address both of these important factors in his opinion is troubling. Moreover, although Dr. Goldstein observed that the Claimant had significant problems with walking and that he walked with a cane, Dr. Goldstein did not discuss the role, if any, of the Claimant's leg problems regarding his respiratory impairment. For these reasons, I find Dr. Goldstein's opinion not well-reasoned, and I give it little weight.

As noted above, I have found that the X-ray evidence regarding pneumoconiosis is equivocal. However, as the regulation recognizes, an individual can have pneumoconiosis, notwithstanding a negative X-ray; the regulation also recognizes that a physician can determine the value of a negative X-ray in determining the presence or absence of pulmonary disease. § 718.202(a)(4). See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79920, 79945 (Dec. 20, 2000). Consequently, Dr. Hawkins' diagnosis that the Claimant had coal workers' pneumoconiosis is not incongruous, even though

[20] Dr. Khan's report suggests that he has diagnosed the Claimant with both "clinical" and "legal" pneumoconiosis, in that he bases his diagnosis in part on a positive X-ray. However, he also ascribes a portion of the Claimant's impairment to cigarette smoke. I find, however, that Dr. Khan's discussion of cigarette smoking as a contributory factor is conclusory at best. Therefore, I find that Dr. Khan's report does not establish that the Claimant has "legal" pneumoconiosis.

the only X-ray he referred to was a negative one.[21] Dr. Hawkins also pointed to other evidence of respiratory impairment, and stated that coal mine dust exposure "likely" accentuated the Claimant's chronic obstructive pulmonary disease, and pointed out that the Claimant has not smoked cigarettes since 1989. Dr. Hawkins' conclusion that the Claimant's chronic obstructive pulmonary disease was likely worsened by his coal dust exposure seems to be a conclusion that the Claimant has "legal" pneumoconiosis, as defined in the regulation. However, I find that this equivocal statement is insufficient to establish that the Claimant's chronic obstructive pulmonary disease "arose" from his coal mine employment, as the regulation requires. See § 718.201(b). Therefore, I give his equivocation little weight.

Based on the foregoing, I find that both Dr. Khan and Dr. Hawkins' conclusions, that the Claimant has pneumoconiosis, are well-reasoned and supported by the evidence.[22] Specifically, I find that the evidence establishes that the Claimant has clinical pneumoconiosis. However, although the evidence also establishes that the Claimant has chronic obstructive pulmonary disease, the only evidence linking this condition to the Claimant's coal mine employment is conclusory (Dr. Khan) or equivocal (Dr. Hawkins). Therefore, I find that this evidence is insufficient to establish that the Claimant's chronic obstructive pulmonary disease "arose" from his coal mine employment.

Considering all the evidence together, I find that the Claimant has established, by a preponderance of evidence, that he has pneumoconiosis, as defined in the applicable regulation. This constitutes a change in the adjudication of the conditions of entitlement since 2000, when the Claimant failed to establish this condition.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). In this case, I have found that the Claimant has established 20 years of coal mine employment. Therefore, he is entitled to the presumption.

I also have found that the Claimant has established that he has pneumoconiosis. The Employer has not proffered any evidence to rebut this presumption, as it relates to the Claimant's clinical pneumoconiosis. Therefore, I find that the Claimant has established, by a preponderance of evidence, that his pneumoconiosis arose from his coal mine employment. This constitutes a change in the Claimant's establishment of conditions of entitlement since 2000, the date of his previous denial of benefits.

c. Whether the Claimant is Totally Disabled

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[21] As set forth above, I have disregarded Dr. Hawkins' discussion of the X-ray of 8/2/2006 in assessing his medical opinion.

[22] These conclusions are not necessarily inconsistent with Dr. Goldstein's conclusion regarding the etiology of the Claimant's chronic obstructive pulmonary disease. They are, however, inconsistent with Dr. Goldstein's conclusion that the Claimant does not have coal workers' pneumoconiosis.

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b) (1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment …requiring the skills and abilities comparable to those of any employment in a mine or mine in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability:

(1) pulmonary function tests with values below a specified threshold;
(2) arterial blood gas tests with results below a specified threshold; or
(3) a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i), (ii) and (iii).
(4) Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

Pulmonary Function Tests

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.204(b) (2) (i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The record contains the following pulmonary function tests:

Date of Test	Physician	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
02/23/2005	Khan	1.91 2.25*	2.85 3.35*	79 82*	67% 67%*	Unknown[23]

[23] It does not appear that flow-volume loops were submitted for all trials. Part 718, Appendix B of the governing regulation requires at least three trials, and also mandates that the original flow-

07/06/2005	Goldstein	1.74 2.06*	2.79 3.34*	66 81*	62% 62%*	Yes
08/02/2006	Hawkins	1.99	No record	69	54%	Unknown[24]

* These values were obtained after a bronchodilator was administered.

At the time these tests were administered, the Claimant, who was born in February 1941, was 64 or 65 years old. The records reflect that he is 73 to 74 inches tall.[25] Where the record reflects different heights, the fact-finder must resolve the conflict. Protopappas v. Director, OWCP, 6 B.L.R. 1-221 (1983). This is particularly important when the discrepancies may affect whether the tests are "qualifying." Toler v. Eastern Associated Coal Co., 42 F.3d 3 (4th Cir. 1995). I find the Claimant is 73.5 inches tall, which is the average of the reported heights. For a male age 64, at 73.5 inches, the qualifying value for the FEV_1 is 2.24, the qualifying value for the FVC is 2.86 and the qualifying value for the MVV maneuver is 90. For a male of the same height at age 65, the qualifying value for the FEV_1 is 2.23, the qualifying value for the FVC is 2.85 and the qualifying value for the MVV maneuver is 89. Finally, the qualifying value for the FEV_1/FVC ratio is 55%.

The Claimant's values on both "before bronchodilators" tests are qualifying under the regulations, because both his FEV_1 and MVV values are qualifying. On the "after bronchodilator" studies test, his FEV_1 was just barely non-qualifying on the February 2005 "after bronchodilator" test; however, the Claimant demonstrated qualifying values on the July 2005 test.

On consideration of all of the evidence, I find the qualifying pulmonary function study results on several of the tests, conducted on different dates, outweigh the single non-qualifying test, which netted a result just above the qualifying value. I note also that the tests Dr. Goldstein administered, which are unquestionably valid, produced qualifying results, whereas the remaining tests may be of questionable validity because complete documentation was not provided.

Based on the foregoing, therefore, I find that the Claimant has established total disability under subsection 718.204(b)(2)(i).

Arterial Blood Gas Tests

A claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a

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volume loops be submitted. The regulation does not require measurement after bronchodilators are administered.

[24] Dr. Hawkins reported results from pulmonary function study in the body of his medical opinion report, however, the tracings and laboratory report were not included in the record (CX 7).

[25] Dr. Hawkins' report does not reflect the Claimant's height.

specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

The following arterial blood gas tests are included in the record:

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)
02/23/2005	Khan	41.7	79.9	Not done	Not done
07/06/2005	Goldstein	41.0	87.0	Not done	Not done

The altitude at which Dr. Khan conducted his test is recorded as less than 2999 feet. The altitude at which Dr. Goldstein conducted his test is not recorded, but I presume it is at less than 2999 feet of altitude.[26] For PCO_2 values at 41, the qualifying PO_2 value is 60 at altitudes of 2999 feet or less. The Claimant's values are well above the qualifying values. Similarly, Dr. Hawkins, whose office is also located in Birmingham, Alabama, reported in the text of his medical report that Claimant demonstrated a PCO_2 of 37.0 with a PO_2 of 73.[27] These values are also non-qualifying under the regulations.

Based on the foregoing, therefore, the Claimant is unable to establish total disability by means of arterial blood gas test results.

Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). Although I have found that the Claimant has established that he has pneumoconiosis, the record in this case contains no evidence of cor pulmonale with right sided congestive heart failure in the Claimant. Accordingly, I find that the Claimant has not established total disability under this provision.

Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the

[26] Dr. Goldstein's letterhead states that his office is located in Birmingham, Alabama. The altitude of Birmingham is approximately 600 feet. See http://www.city-data.com/city/Birmingham-Alabama.html.

[27] No other information about this test is included in the record.

clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

As noted above, Dr. Khan concluded that the Claimant would be unable to do his last coal mine employment due to his respiratory impairment. This report includes, as an enclosure, the Claimant's listing of employment that he completed in conjunction with his application, and also reflects that the Claimant's last coal mine job was as a heavy equipment operator (DX 13). Dr. Goldstein did not specifically conclude whether the Claimant's respiratory condition would prevent him from performing his usual coal mine employment (DX 14). Dr. Hawkins stated that the Claimant is "completely incapacitated" by his resting and exertional hypoxemia (CX 7).

It is unclear, from the evidence of record, whether Dr. Khan understood the physical exertion requirements of the Claimant's most recent coal mine employment. However, Dr. Hawkins' report, which was written about a year and a half after Dr. Khan's report and which reflects that the Claimant's respiratory condition has not changed appreciably, stated that the Claimant is "totally incapacitated." This conclusion, which indicates that the Claimant is disabled from any employment whatsoever based upon his respiratory impairment, is consistent with the evidence adduced through pulmonary function testing.

Consequently, I find that the Claimant has established, through physician opinion, that he is totally disabled as provided in § 718.204(b)(2)(iv). On consideration of all of the evidence, I find that the Claimant has established, by a preponderance of evidence, that he is totally disabled, as defined in the governing regulation. This constitutes a change in a condition of entitlement since 2000, when the Claimant's previous claim for benefits was denied.

d. Whether the Claimant's Total Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Peabody Coal Co. v. Smith, 127 F.3d 504 (6th Cir. 1997). The regulation provides that pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As set forth above, I have found that the Claimant is totally disabled from a pulmonary standpoint. I also have found that the Claimant has pneumoconiosis. What remains to be considered is to what extent, if at all, the Claimant's pneumoconiosis contributes to his total disability.

In this case the evidence clearly indicates that the Claimant suffers from a number of serious medical conditions, several of which impact on his pulmonary health. Although three physicians examined the Claimant, only one of them stated that the Claimant's pneumoconiosis played a role in his respiratory impairment. That physician, Dr. Khan, is the least well-qualified of the three physicians to render such an opinion, as he is the only one who is not a pulmonary specialist.

Moreover, Dr. Khan's brief opinion, consisting only of the words "significant extent," relates to the impact of two factors, heart disease and pneumoconiosis. The regulation requires that pneumoconiosis, in itself, have a "material adverse effect" on the Claimant's pulmonary impairment. § 718.204(c)(1). Although Dr. Khan's comment makes it clear that these two factors together have a significant impact, I cannot infer, from Dr. Khan's notation, the relative contributions of these two factors. Specifically, I cannot determine whether Dr. Khan has concluded that the Claimant's cardiac condition plays the more critical role, or that the Claimant's pneumoconiosis is a more significant contributor, or that the two factors are equal in causing the Claimant's disability.

All three physicians who examined the Claimant noted that his cardiac disease is a factor in his current condition. Dr. Goldstein, as noted above, did not directly address the issue of disability, but noted that the Claimant's heart disease possibly played a role in his shortness of breath. Dr. Khan stated that the Claimant's ischemic heart disease contributed to his disability to a "significant extent." Dr. Hawkins did not specifically cite the role that the Claimant's pneumoconiosis played in his impairment, but he stated that the Claimant's underlying coronary artery disease added "a substantial impairment to his respiratory component." Additionally, Dr. Khan and Dr. Hawkins both noted that the Claimant's degenerative leg condition played a role in his impairment, the former stating it was a factor to "some extent" and the latter stating that it was perhaps significant.

Based on the foregoing, where the only evidence that the Claimant's pneumoconiosis played a significant role in his pulmonary impairment is the unsupported statement by a physician who is not a pulmonary specialist, I am unable to find that the Claimant is totally disabled due to pneumoconiosis.[28] I must conclude, therefore, that the Claimant is unable to establish, by a preponderance of evidence, that his total disability is due to pneumoconiosis.

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[28] As noted above, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." This standard does not require that dust exposure be the sole cause, or even the greatest contributing cause, of the pulmonary impairment. What is required, under the regulation, is a demonstrably significant relationship between dust exposure and the respiratory condition. As set forth above, I have found that Dr. Hawkins' unsupported statement that the Claimant's coal mine dust exposure "likely" accentuated his chronic obstructive pulmonary disease, is insufficient to establish this relationship. The other medical opinions do not conclude that there is any relationship between the Claimant's chronic obstructive pulmonary disease and his coal mine employment.

This represents no change since October 2000, the date of the denial of the Claimant's previous claim.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established a change in all the applicable conditions of entitlement to benefits under the Act since the date of his previous denial. Consequently, I must deny the Claimant's current claim for benefits. § 725.309(d).

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is **DENIED**.

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ADELE H. ODEGARD
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).